MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05888

Reg. Dist. No. 77

1. PLACE OF DEATH:
County: Carroll
City or town: Hampstead
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Carroll
City or town: Hampstead
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Emma Alban

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M.

6.(b) Name of husband or wife: James T Alban
6.(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): Jan 18 1868

8. AGE:

Years	Months	Days	If less than one day
79	5	13	...hrs. ...min.

9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Jesse Hurs
13. Birthplace: Md
MOTHER 14. Maiden name: Eliza J McComas
15. Birthplace: Md
16. Informant: James Williams
Address: Hampstead Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 4/47 (month) (day) (year)
Cemetery or crematory: Grave Run
Location: Balto Co. Md
18. Funeral director: Edw Stipton
Address: Hampstead Md
19. July 2 1947 John S. Hughes Jr. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1947 at 7 30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18 1947 to July 1 1947
and that I last saw h[illegible] alive on June 30 1947
Immediate cause of death: Cerebral Hemorrhage

	DURATION
Due to:	
Due to: General Senility	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: — Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE: Joseph E. Buckland M. D. or other
Address: Hampstead Md Date signed 7-1-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05889

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 years, 3 months, 9 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 23 years, 3 months, 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: 6000 York Road
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: EDNA A. ALLMAN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 29, 1887

8. AGE: Years	Months	Days	If less than one day
60	1	1	..... hrs. ..... min.

9. Birthplace: Baltimore County, Maryland (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business

FATHER
12. Name: George Ruppert
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Gertrude M. Butler
15. Birthplace: Baltimore, Maryland

16. Informant: Hospital records
Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal? Which?) Date thereof Aug. 2, 1947 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore

18. Funeral director: William Cook, Inc.
Address: 1217 St. Paul St.

19. July 31 1947 (Date rec'd by registrar) C. A. Henry (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30th 1947 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 1st 1942 to July 30th 1947 and that I last saw her alive on July 30th 1947

Immediate cause of death	DURATION
Thrombosis of ~~inferior~~ superior mesenteric artery	13 days
Due to: chronic myocarditis	6 years
Due to:	
Other conditions: Schizophrenia, paranoid type	24 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Irene Hitchman, M.D.
M. D. or other
Address: Springfield State Hosp. Date signed: 7-30-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

05890

CERTIFICATE OF DEATH

Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County: Carroll
City or town: Hampstead Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Hampstead Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Erba Sherman Armacost

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Annie Armacost
6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): July 19, 1876

8. AGE:

Years	Months	Days	If less than one day
70	11	18	hrs. min.

9. Birthplace: Hampstead Md
(Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business:

FATHER
12. Name: Augusta Armacost
13. Birthplace: Maryland

MOTHER
14. Maiden name: Kizzie Martin
15. Birthplace: Maryland

16. Informant: Mrs Laurence D Fuss
Address: Baltimore Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 9-47 (month) (day) (year)
Cemetery or crematory: Grace Methodist
Location: Brooklyn Md
18. Funeral director: Edw A Yiklon
Address: Hampstead Md

19. July 8 (Date rec'd by registrar) 19 47 John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7 19 47, at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3 19 47, to July 7 19 47 and that I last saw him alive on July 7 19 47

	DURATION
Immediate cause of death: Coronary Occlusion	12 hrs
Due to: Coronary Heart Disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Dr. E. Buck M.D. M. D. or other
Address: Hampstead Md Date signed 7-7-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

05891

Reg. Diat. No. 71

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Finksburg, Route 1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Finksburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Route 1
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Martha A. Barnes

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: John W. Barnes
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 7, 1850

8. AGE: Years	Months	Days	If less than one day
97	0	21	hrs. min.

9. Birthplace: Carroll County, Maryland
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: James Hook
13. Birthplace: Maryland

MOTHER
14. Maiden name: Rachael Beaver
15. Birthplace: Maryland

16. Interment: Mrs. Mary E. Haines
Address: Gamber, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 7/31/47 (month) (day) (year)
Cemetery or crematory: Deer Park Cemetery
Location: Smallwood, Md.

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 7/25 (Date rec'd by registrar) 19 47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 19 47, at 6 p. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/1/35 19 to 7/28/47 19
and that I last saw h[illegible] alive on 7/28/47 19

Immediate cause of death	DURATION
Myocardial failure	1 yr.
Due to: Coronary thrombosis	
Due to: Hypertension	
Due to: Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Reisterstown Md. Date signed 7/28/47

STATE OF MARYLAND—CERTIFICATE OF DEATH

06483 B

940

1. PLACE OF DEATH

County Carroll Registration Dist. No.

Village or City Finksburg, P.O. No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U.S. if of foreign birth? ___ yrs. ___ mos. ___ ds.

2. FULL NAME Julia Clay Beatley

(a) Residence: No. Finksburg, Md St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS		
3. SEX Female	4. COLOR OR RACE White	5. ~~SINGLE, MARRIED,~~ WIDOWED, ~~OR DIVORCED~~ (write the word) Widowed

5a. If ~~married~~, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or) WIFE of Luther T. Beatley

6. DATE OF BIRTH (month, day, and year) Aug 15th 1869

7. AGE Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
77	11	14	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. At Home

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Self

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto. Md.

FATHER

13. NAME Ebenezer C. Stewart

14. BIRTHPLACE (city or town) (State or country) Md.

MOTHER

15. MAIDEN NAME Maggie Bloss

16. BIRTHPLACE (city or town) (State or country) Md

17. INFORMANT Margaret F. Hewitt (Address) Finksburg Md.

18. BURIAL, ~~CREMATION, OR REMOVAL~~

Place London Park Balto. Md Date Aug 1st, 1947

19. UNDERTAKER William Cook Inc. (Address) 1217 St. Paul St

20. FILED 7/30, 1947 A. C. Hedrick Dov Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH July 29, 1947 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from ___, 19___, to ___, 19___

I last saw h___ alive on ___, 19___; death is said to have occurred on the date stated above, at 3:30 P m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows: Date of onset

Coronary Thrombosis 7-29-47

Other Contributary Causes of importance:

Name of operation Date of

What test confirmed diagnosis? None Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ___ Date of injury ___, 19___

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Maurice C. Porterfield M. D.

(Address) Hampstead Md. acting Dep. Health Comm. Carroll County

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

05892

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9/a

CERTIFICATE OF DEATH

Reg. Diat. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Route 5
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: Granville J. Beaver

3.(b) Social Security Number: 217-03-5295A

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Evelyn Null Beaver
6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): December 12, 1870

8. AGE: Years	Months	Days	If less than one day
76	6	20	....hrs. ....min.

9. Birthplace: Carroll County, Maryland (Town, county, and state)
10. Usual occupation: Laboroer
11. Industry or business: Distillery

FATHER
12. Name: William J. Beaver
13. Birthplace: Maryland

MOTHER
14. Maiden name: Margaret A. Davis
15. Birthplace: Maryland

16. Informant: Joseph H. Beaver
Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 7/5/47 (month) (day) (year)
Cemetery or crematory: Deer Park Cemetery
Location: Smallwood, Md.

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 7/4 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2 19 47 at 9:30A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 20 19 47 to July 2 19 47 and that I last saw him alive on July 1 19 47

Immediate cause of death	DURATION
Coronary Occlusion	11 da
Due to: Arterio-Sclerosis (General)	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ....Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wilbur Speicher M. D. or other
Address: Westminster Md. Date signed: 7/5/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

CERTIFICATE OF DEATH

65893

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DEACEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1 Westmoreland
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Edwin D. Bell

3.(b) Social Security Number 218-07-7448

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Barbara Eichorn
6.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) March 24 - 1870

8. AGE: Years	Months	Days	If less than one day
77	3	28	hrs. min.

9. Birthplace Emmitsburg, Md.
(Town, county, and state)
10. Usual occupation Weighmaster
11. Industry or business Lumber Coal Co
FATHER 12. Name Joseph Bell
13. Birthplace Md.
MOTHER 14. Maiden name Not Known
15. Birthplace " "
16. Informant Clarence Bell
Address Westminster, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 24-1947 (month) (day) (year)
Cemetery or crematory Westminster
Location Westminster, Md.
18. Funeral director H. Bankard & Son
Address Westminster, Md.
19. 7/23 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 19 47 at 9 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1st 1943 to July 22 1947
and that I last saw him alive on July 22 1947
Immediate cause of death Acute Cardiac Dilatation — Duration 3 days
Chronic Myocarditis — 2 yrs
Due to Valvular Insufficiency — 10 yrs
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas. R. Fouts M.D. M. D. or other
Address Westminster Md. Date signed 7-22-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

CERTIFICATE OF DEATH

6484

Reg. Diat. No. 81

1. PLACE OF DEATH:
County: Carroll
City or town: Union Bridge (If outside city or town limits, write RURAL and give nearest town) Rural
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Union Bridge (If outside city or town limits, write RURAL and give nearest town) Rural
Street No.: Frecsuburg (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lizzie J. Birely

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 3 - 1864

8. AGE:

Years	Months	Days	If less than one day
82	7	20	..... hrs. ..... min.

9. Birthplace: Carroll County Md. (Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business:
FATHER — 12. Name: Francis J. Birely
FATHER — 13. Birthplace: Maryland
MOTHER — 14. Maiden name: Susan L. Engel
MOTHER — 15. Birthplace: Maryland
16. Informant: Lowell M. Birely
Address: Union Bridge, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 25-1947 (month) (day) (year)
Cemetery or crematory: Mt Union Cemetery
Location: Union Bridge R. D. Md.
18. Funeral director: D. D. Shriver & Sons
Union Bridge & New Windsor Md
19. July 24 1947 (Date rec'd by registrar) H Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23 1947 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944 to July 23 1947 and that I last saw h.. alive on July 23 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J. H. Mussler M.D. M. D. or other
Address: Johnsville Date signed: July 24

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87e

05894

CERTIFICATE OF DEATH

Reg. Dist. No. 76

M

1. PLACE OF DEATH:

County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. # 4

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Roger Boone

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife —

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27 1945

8. AGE:

Years	Months	Days	If less than one day
2	0	6	hrs. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER

12. Name Ray Boone

13. Birthplace Virginia

MOTHER

14. Maiden name Dorothy Adams

15. Birthplace Wellsburg, W. Va.

16. Informant Ray Boone

Address Westminster R.D. 4. Md.

17. Burial Date thereof July 3 1947

(Burial, cremation, or removal. Which?) (Month) (day) (year)

Cemetery or crematory Westminster (Md.)

Location " " "

18. Funeral director H. Bankard & Son

Address Westminster, Md.

19. 7/3 1947 [signature] Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1947, at 1 D.S.T. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27 1945, to July 2 1947

and that I last saw him alive on July 1st 1947

	DURATION
Immediate cause of death: Convulsions	3 days
Due to: Brain injury Connected with Spastic diplegia	about 2 yrs
Due to: Erythroblastosis fetalis	2 yrs 3 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Reese Wilbern M.D.

M. D. or other

Address Westminster Date signed 7/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

05895

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs., 1 mo., 18 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 35 yrs., 1 mo., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME

PHILIP ARTHUR BOOZ

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1885

8. AGE: Years	Months	Days	If less than one day
62			hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: hat maker

11. Industry or business:

FATHER
12. Name: William Booz
13. Birthplace: Maryland

MOTHER
14. Maiden name: Anna Bigby
15. Birthplace: Maryland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 8, 1947 (month) (day) (year)

Cemetery or crematory: Springfield Hospital Cem.

Location: Sykesville, Md.

18. Funeral director: C. Harry Uhler

Address: Sykesville, Md.

19. July 8 1947 C. Harry Uhler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2 1947 at 12:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to July 2 1947 and that I last saw him alive on July 2 1947

Immediate cause of death	DURATION
Arteriosclerosis	Prior to 1946
Due to:	
Due to:	
Other conditions: Schizophrenia, hebephrenic	37 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D. M.D. or other

Address: Sykesville, Maryland Date signed: 7-3-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

05896

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH

County: Carroll

City or town: Manchester Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 days.

Hospital, institution, or street address where death occurred: Long-View Nursing Home

How long in hospital or institution? 30 Days.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Manchester Maryland (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Rebecca Bowers.

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife: Newton Bowers

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Sept 4, 1859

8. AGE: Years 87 Months ?10 Days ?2 If less than one day ... hrs. ... min.

9. Birthplace (Town, county, and state): Manchester Maryland

10. Usual occupation: none

11. Industry or business

FATHER

12. Name: Samuel Mathias

13. Birthplace: Carroll Co, Md

MOTHER

14. Maiden name: Catharine Hare

15. Birthplace: Carroll Co, Md

16. Informant: Mrs Kathleen Wells

Address: Manchester, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 8, 1947 (month) (day) (year)

Cemetery or crematory: Mt Olivet

Location: Hanover Pa.

18. Funeral director: W. G. Fesser

Address: Hanover.

19. July 7th 1947 (Date rec'd by registrar) Mrs. W. R. S. Denner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6 1947, at 8:10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 18 1947, to July 6 1947 and that I last saw her alive on July 5 1947

Immediate cause of death: Chronic Myocarditis

DURATION

Due to: Generalized Arterio-Sclerosis

Due to:

Other conditions (Include pregnancy within 3 months of death): Gangrene of feet

Major findings of operations: —

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — injured at work?

23. SIGNATURE: Joseph E. Buch M.D. M. D. or other

Address: Hampstead Md Date signed 7-6-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74 — 05897

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 4 mo's.

Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 608 Eisler Street

(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: MILTON BROWN

3.(b) Social Security Number: 158-07-4511

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Margaret Brown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
40	10	29	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Joseph Brown

FATHER — 13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden name: Estelle Williams

MOTHER — 15. Birthplace: Baltimore, Md.

16. Informant: Deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 10 47 (month) (day) (year)

Cemetery or crematory: Mt Calvary

Location: A A Co. Md.

18. Funeral director: Sarah L Brown Son

Address: 1080 Monty omery St

19. 7/8 (Date rec'd by registrar) 19 47 Albert R. Swanbaum Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8, 19 47, at 10.00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8, 19 46, to July 8, 19 47 and that I last saw h... im alive on July 8, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben H Kahn M.D. M. D. or other

Address: Henryton, Md. Date signed 7/8/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

57d

05898

Reg. Diat. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Frederick
City or town: Point of Rocks
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
MILDRED MARIE CLEVENGER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: Richard Clevenger
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 8/16/25

8. AGE: Years	Months	Days	If less than one day
21	11	1	hrs. min.

9. Birthplace: Washington, D. C. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Louis Grey
13. Birthplace: Carroll County, Maryland

MOTHER
14. Maiden name: Unknown
15. Birthplace: Carroll County, Maryland

16. Informant: Record, Springfield State Hospital
Address: Sykesville, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof July 17, 1947 (month) (day) (year)
Cemetery or crematory:
Location: Silver Spring, Maryland
18. Funeral director: Adams E. Pumphrey
Address: Silver Spring, Maryland

19. July 17 19 47 (Date rec'd by registrar) C. Henry Ward Registrar

MEDICAL CERTIFICATION (DST)

20. DATE OF DEATH: 7/17/ 19 47, at 5:15 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/12 19 47 to 7/17 19 47
and that I last saw her alive on 7/17 19 47

Immediate cause of death	DURATION
Brain Tumor, type undetermined	probably 1 month
Due to	
Due to	
Other conditions: 26 days post-partum. Death was not due to puerperal condition. (Include pregnancy within 3 months of death)	

8/27/47 as.

Major findings of operations
Date of op.
Autopsy results: As above; endometrial tumor
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Arnold H. Tichert M.D. M. D. or other
Address: Sykesville, Maryland Date signed 7/17/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05899

Reg. Dist. No. 74

1. PLACE OF DEATH:

County

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 month, 14 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. #2
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME LILLIAN GOLDIE GOLLICK

3.(b) Social Security Number 213-22-9738

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 14, 1927

8. AGE: Years	Months	Days	If less than one day
19	9	11	hrs. min.

9. Birthplace Pocomoke City, Md.
(Town, county, and state)

10. Usual occupation Seamstress

11. Industry or business

FATHER 12. Name James B. Collick

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Lillian Rounds

MOTHER 15. Birthplace Maryland

16. Informant Mrs. Lillian Collick

Address Pocomoke City, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-28-47 (month) (day) (year)

Cemetery or crematory Collick Cemetery

Location Snow Hill

18. Funeral director C E Dennis

Address Snow Hill

19. 7/25 (Date rec'd by registrar) 19 47 Allen R Snowden Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25, 19 47, at 9.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 11, 19 47, to July 25, 19 47 and that I last saw her alive on July 25, 19 47

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Sept. 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reuben W Kerman, M D M. D. or other

Address Henryton, Md Date signed 7/25/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05900

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 8 mo's., 3 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Somerset

City or town: Westover
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 1, Box 203
(If rural, give LOCATION)

2.(a) If veteran, name war: World War 1

3.(a) FULL NAME

BRANCESOM LEROY COLLINS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 26, 1897

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
50	6	3		

9. Birthplace: Westover, Md.
(Town, county, and state)

10. Usual occupation: Farm Laborer

11. Industry or business:

FATHER
12. Name: Samuel Collins
13. Birthplace: Fairmount, Md.

MOTHER
14. Maiden name: Elizabeth Fulks
15. Birthplace: Westover, Md.

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 3 1947 (month) (day) (year)

Cemetery or crematory: Westover

Location: Westover, Md

18. Funeral director: Charles H Ward

Address: Marion Sta. Md.

19. 7/29 19 47 (Date rec'd by registrar) Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29, 1947, at 9.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 26, 1945, to July 29, 1947 and that I last saw him alive on July 29, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 15 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other

Address: Henryton, Md Date signed: 7/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05901

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 17 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1721 W. Franklin Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: WILLIAM CREECY

3.(b) Social Security Number: 214-03-2943

4. Sex: Male

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Virgie Creecy

6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): September 10, 1908

8. AGE: Years: 38 Months: 10 Days: 17 If less than one day: hrs. min.

9. Birthplace: Creswell, North Carolina
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Herbert Creecy
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Alitha Reese
15. Birthplace: North Carolina

16. Informant: Deceased
Address

17. Shipped (Burial, cremation, or removal. Which?) Date thereof 7/30/1947 (month) (day) (year)
Cemetery or crematory
Location Creswell North Carolina

18. Funeral director: Katie R. William
Address 312 N. Schoolhouse St

19. 7/27 19 47 (Date rec'd by registrar) Albert R. Swantham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27, 19 47 at 8.30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10, 19 47 to July 27, 19 47 and that I last saw h... im alive on July 27, 19 47

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Feb., 1947

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben W. Brown, M. D. M. D. or other
Address Henryton, Md Date signed 7/27/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05902

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 9 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4 Vinsant Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MARY OLOVIA DAVIS

3.(b) Social Security Number: 212-16-0704

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Cornell Davis
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): April 1, 1913

8. AGE: Years	Months	Days	If less than one day
34	3	24	..... hrs. ..... min.

9. Birthplace: Calvert County, Md. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: John H. Harris
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary J. Levi
15. Birthplace: Maryland.

16. Informant: Gertrude Randolph
Address: 18 Vansant St. Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/29/47 (month) (day) (year)
Cemetery or crematory: Brewers Hill
Location: West St. Extended
18. Funeral director: Mrs. Ida E. Wicks
Address: 43-45 Northwest Street

19. 7/25 (Date rec'd by registrar) 19 47 Albert R. Swansbrough Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 25, 1947, at 9.45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16, 1947, to July 25, 1947 and that I last saw her alive on July 25, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan., 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Ruben W. Foman M.D. M. D. or other
Address: Henryton, Md. Date signed: 7/25/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05903

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: ~~Allegany~~ Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 7/17/47

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 33 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Altamont Hotel

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: ALICE DEVIER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife: ~~Unknown~~ x

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown ~~xxxxx~~ Oct. 8, 1865

8. AGE: Years	Months	Days	If less than one day
~~82~~ (?) 81	9	9	hrs. min.

9. Birthplace: Unknown Nurse (Town, county, and state)

10. Usual occupation: Unknown ~~xxxxx~~ Virginia

11. Industry or business

FATHER

12. Name: Unknown Allan Devier

13. Birthplace: Unknown ~~xxxxx~~ Virginia

MOTHER

14. Maiden name: Unknown Nancy Mc. Dormand

15. Birthplace: Unknown Virginia

16. Informant: Record, Springfield State Hospital

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 23, 1947 (month) (day) (year)

Cemetery or crematory: Woodbine Cem.

Location: Harrisonburg, Va.

18. Funeral director: Higgs Funeral Home

Address: Harrisonburg, Va.

19. July 21 1947 (Date rec'd by registrar) Nancy Hess Registrar

MEDICAL CERTIFICATION DST.

20. DATE OF DEATH: July 18 1947 at 11 08 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 1947 to July 18 1947 and that I last saw him alive on July 18 1947

Immediate cause of death	DURATION
Bronchopneumonia	7/18/47
Due to:	
Due to:	
Other conditions: Stru ma, myocarditis	Unknown
Senile Psychosis	X

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Sichert M.D. M. D. or other

Address: Sykesville, Maryland Date signed: 7-19-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1318

05904

CERTIFICATE OF DEATH

Reg. Diat. No. 76

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:
County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. Penn. Ave. Ex Rt 1
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Joseph Abram Dodrer

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Divorced

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 31 - 1891

8. AGE: Years	Months	Days	If less than one day
56	1	23	..... hrs. ..... min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual occupation Farmer: Ret.
11. Industry or business

FATHER
12. Name J Calvin Dodrer
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden name Belle E. Fusbaum
15. Birthplace Carroll Co. Md.

16. Informant Mrs Kenneth Fuser
Address W. Main Westminster, Md.

17. Burial Date thereof July 27-1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rural Cemetery
Location Westminster R.D. Md.

18. Funeral director H Bankard & Son
Address Westminster, Md.

19. 7-27 1947 L Ellwood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1947, at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1930, to July 24 1947
and that I last saw h. alive on July 24 1947

Immediate cause of death	DURATION
Myocarditis (chr)	
Nephritis (chr)	
Uremia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation None Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. C. Jennette, M.D.
M. D. or other
Address Westminster Md Date signed July 25-47


RECEIVED
JUL 29 1947
BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

47d 05905

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years, 5 months, 25 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 2 yrs., 5 mos., 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 206 Ridgemede Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Elizabeth Mary Duggins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	m

6.(b) Name of husband or wife: Richard J. Duggins

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): 10/20/98

8. AGE: Years	Months	Days	If less than one day
48	9	9	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housewife- Real Estate Broker

11. Industry or business

FATHER
12. Name: James O'Brien
13. Birthplace: Maryland

MOTHER
14. Maiden name: Louise Bennett
15. Birthplace: Maryland

16. Informant: Record, Springfield State Hospital

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 2 1947 (month) (day) (year)

Cemetery or crematory: New Cathedral Cem.

Location: Balto. Md.

18. Funeral director: Williams Cook, Inc.

Address: 1217 St Paul St.

19. July 29 1947 (Date rec'd by registrar) C. Harry Klew Registrar

MEDICAL CERTIFICATION (DST)

20. DATE OF DEATH: 7/29 1947 at 7:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/4/ 1945 to 7/29 1947 and that I last saw her alive on 7/29 1947

Immediate cause of death	DURATION
Carcinoma of right lung with metastases to the neck	2 yrs.
Due to:	
Due to:	
Other conditions: Manic Depressive Psychosis, Manic Phase	2½ yrs.

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: M Virginia Beyer M.D. - M. D. or other

Address: Sykesville, Maryland Date signed: 7/29/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Linwood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Linwood

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Blanch V. Fisher

3.(b) Social Security Number: 220-10-5639

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Charles Fisher

6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): May 10, 1884

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
63	1	26		

9. Birthplace: Carroll County, Maryland

(Town, county, and state)

10. Usual occupation: labor

11. Industry or business

FATHER 12. Name: Levi Poulson

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name

MOTHER 15. Birthplace

16. Informant: Mrs. Arthur Bowers

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 7/8/47 (month) (day) (year)

Cemetery or crematory: Stone Chapel Cemetery

Location: Warfieldsburg, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 7/7 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6 1947 at 2 a. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James T. Wood Deputy Med. Examiner M. D. or other

Address: Westminster Md. Date signed 7-6-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05907

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 25 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 521 N. Stricker Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: LUCILLE ANNIE FLOWERS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 26, 1925

8. AGE: Years	Months	Days	If less than one day
21	9	11	hrs. min.

9. Birthplace: Virginia
(Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: Frederick Flowers
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mary Ella Dameron
15. Birthplace: Virginia

16. Informant: Deceased
Address: 521 N. Stricker St

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 10-1947 (month) (day) (year)
Cemetery or crematory: Mt. Calvary Cemetery
Location: Brooklyn
18. Funeral director: Wm. Brooks Tunstall
Address: 1463 N. Carey St

19. July 7, 1947 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7, 1947 at 2:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12, 1947, to July 7, 1947 and that I last saw her alive on July 7, 1947

Immediate cause of death: Pulmonary Tuberculosis — DURATION: April 1947

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Herbert C. Brown, M.D. M. D. or other
Address: Henryton, Md. Date signed: 7-7-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


RECEIVED
JUL 9 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 922

CERTIFICATE OF DEATH

05908

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 47 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. # 4
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Henry Foster

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Jane Davidson 6.(c) If alive, give age 92 years

7. Birth date of deceased (mo., day, yr.) August 17 - 1857

8. AGE: Years	Months	Days	If less than one day
89	10	29	...hrs. ...min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Roderick Foster
13. Birthplace Germany

MOTHER 14. Maiden name Not known
15. Birthplace " "

16. Informant Mrs Adam Foster
Address Westminster R. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 19-1947 (month) (day) (year)
Cemetery or crematory Leisters Cemetery
Location Westminster, Md.

18. Funeral director H. Bankard & Son
Address Westminster Md.

19. 7/18/47 (Date rec'd by registrar) H Bankard Registrar

MEDICAL CERTIFICATION 47

20. DATE OF DEATH July 16 1947, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 13 1947 to July 16 1947 and that I last saw him alive on July 16 1947

Immediate cause of death	DURATION
Myocardial degeneration & Pulmonary Insufficiency	
Due to Arterio Sclerosis (General)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W Glenn Speicher M. D. or other
Address Westminster Md. Date signed 7/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 24a

CERTIFICATE OF DEATH

Reg. Dist. No. 05909

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Rural -- Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural--Sykesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: PAULINE V. GASSAWAY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 22, 1939

8. AGE: Years 8 | Months 2 | Days 22 | If less than one day: hrs. min.

9. Birthplace: Carroll Co/ Maryland (Town, county, and state)

10. Usual occupation: In School

11. Industry or business

FATHER
12. Name: Robert Gassaway
13. Birthplace: Maryland

MOTHER
14. Maiden name: Rose Lee Rhubottom
15. Birthplace: Maryland

16. Informant: Robert Gassaway
Address: Sykesville, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 7-17-47 (month) (day) (year)
Cemetery ~~or crematory~~: White Rock
Location: Berrett, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. July 16 19 47 (Date rec'd by registrar) C. Harry Wenz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14, 19 47, at 2;30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13 19 47 to July 14 19 47 and that I last saw h.e.r. alive on July 13 19 47

Immediate cause of death	DURATION
Septicemia Acute	5 Days
Due to Infection in foot	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. H. Bauer M.D. M. D. or other
Address: Sykesville Md. Date signed July 17 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

05910

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:
County Carroll
City or town Manchester
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 2 mo.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Anna Elizabeth Graf

3.(b) Social Security Number none

4. Sex: Femal
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife —
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): Feb. 20. 1866
8. AGE: Years 81 Months 4 Days 14 If less than one day ... hrs. ... min.
9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: Milliner
11. Industry or business
FATHER 12. Name John L. Graf
13. Birthplace Germany
MOTHER 14. Maiden name Anna E. Schmidt
15. Birthplace Germany
16. Informant Franklin Graf
Address Manchester Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-6-47 (month) (day) (year)
Cemetery or crematory Cemetery
Location Manchester Md
18. Funeral director Jacob Winks Sons
Address Manchester, Md.
19. July 5th, 1947 Mrs. H. R. Deaver
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1947 at 3:30 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 20 1946 to July 4 1947 and that I last saw h— alive on July 3, 1947
Immediate cause of death Uremic Insanity — DURATION
Due to Senility & Arteriosclerosis
Due to —
Other conditions —
(Include pregnancy within 3 months of death)
Major findings of operations —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?
23. SIGNATURE Joseph E. Buck M.D.
M. D. or other
Address Hampstead Md Date signed 7-4-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

ec05911

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yrs. 1mo-10 da

Hospital, Institution, or Street address where death occurred: Springfield State Hospital

How long in hospital or institution? 17 yrs 7 mos 10 da

2. USUAL RESIDENCE (HOME) OF DECEASED (For newborn infants give residence of mother)

State: Md. County: Prince Georges Co.

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Hellman Clifford Hart

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29 - 1916

8. AGE: Years 31 | Months 3 | Days 29 | If less than one day ... hrs. ... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Dependent

11. Industry or business

FATHER 12. Name: George Hart

13. Birthplace: Washington DC

MOTHER 14. Maiden name: Nellie R. America

15. Birthplace: Washington DC

16. Informant: Mrs Nellie Hart

Address: 923 W Lombard St Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-31-47 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cem.

Location: Sykesville, Md.

18. Funeral director: C. Harry Derr

Address: Sykesville, Md.

19. July 31 1947 (Date rec'd by registrar) C. Harry Derr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28th 1947 at 1.05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 28th 1929, to July 28 1947

and that I last saw him alive on July 28 1947

Immediate cause of death	DURATION
Broncho Pneumonia	1wk.
Due to	
Due to Epilepsy	28 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Hastings M.D. M. D. or other

Address: Sykesville Md. Date signed 7-31-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

05912

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 yrs 10 mo 21 da

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 23 yrs 10 mo 21 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Prince Geo. Co.

City or town Unk

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Louise M Hill.

3.(b) Social Security Number

4. Sex F | 5. Color or race W | 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife James Hill

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27 1873

8. AGE: Years 73 | Months 9 | Days 9 | If less than one day ... hrs. ... min.

9. Birthplace A. A. Co. Md.

(Town, county, and state)

10. Usual occupation Housework at home.

11. Industry or business

FATHER 12. Name James Owens

13. Birthplace A. A. Co. Md.

MOTHER 14. Maiden name Louise Bowie

15. Birthplace Prince George Co Md

16. Informant James H. Hill

Address Washington D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 7-6-47 (month) (day) (year)

Cemetery or crematory Gaschs Funeral Home

Location Ft Meade Md

18. Funeral director F Gaschs Sons

Address Laytonsville, Md.

19. July 7 1947 C. Harry Wee Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6th 1947 at 3:35 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 14 1923 to July 6 1947 and that I last saw h... alive on July 6 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 da
Due to Arterio Sclerosis	5 yrs
Other conditions Hypertension	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. F. Gaston M.D. M. D. or other

Address Sykesville Md. Date signed 7/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

107

05913

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Springfield State Hospital (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore City

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 3408 Park Heights Ave. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Joseph Holtzman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(c) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Mrs. Ruth Holtzman 6.(c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1914

8. AGE: Years	Months	Days	If less than one day
32	8	15	hrs. min.

9. Birthplace: Norfolk, Va. (Town, county, and state)

10. Usual occupation: Baker

11. Industry or business

FATHER — 12. Name: Abraham Holtzman

13. Birthplace: Poland

MOTHER — 14. Maiden name: Fannie Greenspun

15. Birthplace: Poland

16. Informant: Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 22 1947 (month) (day) (year)

Cemetery or crematory: Pikesville Run

Location: Bayview Lane

18. Funeral director: Sol Levinson & Bros.

Address: 1124-26 W North Ave

19. July 21 1947 (Date rec'd by registrar) Harry Steer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21, 1947 at 4:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16, 1947, to July 21, 1947 and that I last saw him alive on July 21 1947

Immediate cause of death	DURATION
Bronchopneumonia	2 days
Due to: Schizophrenia	6 yrs'
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Joseph N. Marshall, M.D. M. D. or other

Address: Springfield State Hospital Date signed 7/21/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

05914

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 57d

CERTIFICATE OF DEATH

Reg. Dist. No. 71

1. PLACE OF DEATH:

County Carroll

City or town Union Bridge (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Rural

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Union Bridge (If outside city or town limits, write RURAL and give nearest town)

Street No. Rural (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Upton Daniel Hoover

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Bertha Albaugh Hoover

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 3 - 1906

8. AGE: Years	Months	Days	If less than one day
40	11	6	..... hrs. ..... min.

9. Birthplace Frederick County, Maryland (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farmer

FATHER 12. Name Cyprus H Hoover

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Media Delaughter

MOTHER 15. Birthplace Maryland

16. Informant Bertha Albaugh Hoover

Address Union Baidge, Md RD

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 30 - 1947 (month) (day) (year)

Cemetery or crematory Pipe Creek Cemetery

Location near Uniontown

18. Funeral director D D Hartzler & Sons

Address Union Bridge & New Windsor, Md.

19. July 30 1947 (Date rec'd by registrar) Margaret P. England Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1947 at 1:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26 1947, to July 28 1947 and that I last saw h. alive on July 27 1947

	DURATION
Immediate cause of death Intra cran. hem. Brain	
Due to non-Indulgent. 8/27/47	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Legg M. D. or other

Address Union Bridge Date signed 7-28-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05915

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 107 W. York St.,
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: RALPH HUGHES

3.(b) Social Security Number: 057-12-0726

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

8.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec., 6, 1918

8. AGE: Years	Months	Days	If less than one day
28	7	10	hrs. min.

9. Birthplace: Sarasota, Florida
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Rocky Harris Smith
15. Birthplace: Florida

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/2/47 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location:

18. Funeral director: James A. Hayes
Address: 142 N. Bell St. Balto Md

19. 7/16 (Date rec'd by registrar) 19 47 Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 16, 1947, at 9.10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23, 1947, to July 16, 1947
and that I last saw him alive on July 16, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1943
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Neilan C. Wyman, M.D. M. D. or other
Address: Henryton, Md Date signed: 7/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05916

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 792 W. Mulberry Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JOHN LOUIS HUNTER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Married

6.(b) Name of husband or wife: Mary Hunter

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ?, ?, 1884

8. AGE: Years	Months	Days	If less than one day
63	?	?	hrs. min.

9. Birthplace: Montgomery, Alabama (Town, county, and state)

10. Usual occupation: Butcher

11. Industry or business:

FATHER — 12. Name: Charles Hunter

13. Birthplace: Montgomery, Alabama

MOTHER — 14. Maiden name: Mrya (Unknown)

15. Birthplace: Montgomery, Alabama

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/4/47 (month) (day) (year)

Cemetery or crematory: Mt. Auburn Cem

Location:

18. Funeral director: Mrs. Katie R. Williams

Address 322 N. Schroder Street

19. 7/31 (Date rec'd by registrar) 19 47 Albert R. Swanborough Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31, 19 47, at 4.45A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28, 19 47 to July 31, 19 47 and that I last saw him alive on July 31, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1947
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

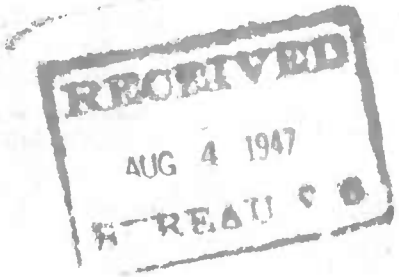
23. SIGNATURE: Reuben W. Swan, M. D. M. D. or other

Address: Henryton, Md Date signed 7/31/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct name is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M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05917

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months, 23 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 557 Oxford Street

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JOSEPHINE JOHNSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 16, 1941

8. AGE: Years	Months	Days	If less than one day
5	8	15	hrs. min.

9. Birthplace: Baltimore, Md (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Joseph Johnson

13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden name: Dorothy Hill

15. Birthplace: Baltimore, Md.

16. Informant: Dorothy Johnson

Address: 557 Oxford Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/4/47 (month) (day) (year)

Cemetery or crematory: Arbutus Memorial Park

Location: Baltimore Co. Maryland

18. Funeral director: Adelbert Forehand

Address: 918 Rhode Island Ave. N.W.

19. 7/31 (Date rec'd by registrar) 19 47 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31, 19 47, at 12.15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 8, 1946, to July 31, 1947 and that I last saw her alive on July 31, 1947

Immediate cause of death: Tuberculosis of the Hip — DURATION: July 1946

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Kuan, M.D. M. D. or other

Address: Henryton, Md Date signed: 7/31/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05918 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 25 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 421 S. Paca Street,
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: SARAH LOUISE Phillips Johnson

3.(b) Social Security Number: 217-22-8197

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	married

6.(b) Name of husband or wife: Robert Johnson
6.(c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.): March 9, 1927

8. AGE: Years	Months	Days	If less than one day
20	4	6	....hrs. ....min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Henry Jackson
13. Birthplace: Virginia
MOTHER 14. Maiden name: Elsie Phillip
15. Birthplace: Virginia
16. Informant: Robert Johnson (Husband)
Address: 421 S. Paca St., Balto. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-19-47 (month) (day) (year)
Cemetery or crematory: Union Prospect Cem.
Location: Glen Arm Co. Md.
18. Funeral director: Wayne Sanders
Address: 1412 Preston St.
19. July 15, 1947 (Date rec'd by registrar) Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15, 1947, at 5:15A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 20, 1947, to July 15, 1947 and that I last saw her alive on July 15, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1946
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Wyman M.D. M. D. or other
Address: Henryton, Md. Date signed: 7-15-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13 P

05919

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years, 2 mos. 10 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 7 years, 2 mos., 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 24 East Bradley Lane

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: DOROTHY JONES

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	S

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 8/10/11

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
35	11	8		

9. Birthplace: Porto Rico (Town, county, and state)

10. Usual occupation: Nurse

11. Industry or business

FATHER — 12. Name: Chester Jones

13. Birthplace: Newton, Massachusetts

MOTHER — 14. Maiden name: Virginia F. Furst

15. Birthplace: Clear Spring, Maryland

16. Informant: Record, Springfield State Hospital

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7-21-47 (month) (day) (year)

Cemetery or crematory: Arlington National Cem.

Location: Arlington, Va.

18. Funeral director: C. A. Howes Co.

Address: 2901 - 14th St. N.W. Wash. D.C.

19. July 18 19 47 (Date rec'd by registrar) C. Harry Howes Registrar

MEDICAL CERTIFICATION (DST)

20. DATE OF DEATH: 7/18 19 47 at 5:25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/12 19 45, to 7/18 19 47 and that I last saw her alive on 7/18 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 years
Due to:	
Due to:	
Other conditions: Schizophrenia, hebephrenic type (include pregnancy within 3 months of death)	20 years

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D. M. D. or other

Address: Sykesville, Maryland Date signed: 7/18/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

05920

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 3 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1371 Whatcoat St.,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JAMES RANDOLPH KEENE

3.(b) Social Security Number: 216-07-5740

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Beatrice Keene
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 16, 1916

8. AGE: Years	Months	Days	If less than one day
31	6	15	hrs. min.

9. Birthplace: Baltimore, Md (Town, county, and state)
10. Usual occupation: Stevedore
11. Industry or business

FATHER
12. Name: James Keene
13. Birthplace: Cambridge, Md.

MOTHER
14. Maiden name: Bessie Wilmer
15. Birthplace: Kent County, Md.

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 4, 1947 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: Baltimore, Maryland
18. Funeral director: Geo. G. Lebon
Address: 1303 Eastern Avenue

19. 7/31 19 47 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 19 47 at 6.45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28, 19 47 to July 31, 19 47 and that I last saw him alive on July 31, 19 47

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Jan. 23 1947
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md Date signed: 7/31/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05921

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 12 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D.#6
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Elmer King

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 1, 1929

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
18	5	2		

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Dishwasher

11. Industry or business:

FATHER
12. Name: Albert King
13. Birthplace: Maryland

MOTHER
14. Maiden name: Carrie Thomas
15. Birthplace: Maryland

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/7/47 (month) (day) (year)
Cemetery or crematory: Mt. Gregory
Location: Howard County, Md.
18. Funeral director: C. M. Walt
Address: Westminster, Md. R.D.

19. 7/3 (Date rec'd by registrar) 19 47 Albert R. Swanbaum Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3, 19 47, at 9.05A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 21, 19 47, to July 3, 19 47 and that I last saw him alive on July 3, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1947
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Nelson Hoffman, M. D.
M. D. or other
Address: Henryton, Md Date signed: 7/3/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

05922

Reg. Diat. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Warfieldsburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Warfieldsburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3. (a) FULL NAME: Clarence M. Lantz

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Wivie R. Cook Lantz

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): October 24, 1868

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
78	8	15		

9. Birthplace: Carroll County, Maryland
(Town, county, and state)

10. Usual occupation: farmer

11. Industry or business

FATHER
12. Name: Theodore Lantz
13. Birthplace: Maryland

MOTHER
14. Maiden name: Hannah Sellman
15. Birthplace: Maryland

16. Informant: Mrs. George E. Knox
Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 7/12/47 (month) (day) (year)

Cemetery or crematory: Stone Chapel Cemetery

Location: Warfieldsburg, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 7/10 19 47 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 9 19 47, at 8 p. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30th 1947, to July 9th 1947 and that I last saw him alive on July 9th 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	9 days
Due to arterio-sclerosis	5yrs.?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: J. T. Billingslea, M.D.
M. D. or other

Address: Westminster, Md. Date signed: 7-9-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87d

05923

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:
County: Carroll
City or town: Taneytown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Taneytown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mabel S. Leister

3. (b) Social Security Number: 220-09-8465

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 8, 1896

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
51	5	29		

9. Birthplace: Carroll County, Maryland (Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER — 12. Name: Jesse M. Leister
13. Birthplace: Maryland
MOTHER — 14. Maiden name: Cora J. Lawyer
15. Birthplace: Maryland
16. Informant: Mrs. Norman Reindollar
Address: Taneytown, Maryland.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 10, 1947 (month) (day) (year)
Cemetery or crematory: Lutheran Cemetery
Location: Taneytown, Maryland.
18. Funeral director: C. O. Haas & Son
Address: Taneytown, Maryland.
19. July 9 1947 (Date rec'd by registrar) Mary E. Welk Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7, 1947, at 6 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18, 1940, to July 7, 1947
and that I last saw h.e.r alive on July 7, 1947
Immediate cause of death: Multiple Sclerosis — DURATION: 2 yrs.
Due to:
Due to:
Other conditions: Hypertension — 10 yrs.
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results: None Done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. S. McVaugh M.D. (M. D. or other)
Address: Taneytown, Md. Date signed: 7/8/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

05924

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 4
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: Andrew Jackson Long

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 1, 1865

8. AGE: Years	Months	Days	If less than one day
82	3	30	hrs. min.

9. Birthplace: Carroll County, Maryland
(Town, county, and state)

10. Usual occupation: farmer

11. Industry or business:

FATHER
12. Name: Jesse Long
13. Birthplace: Maryland

MOTHER
14. Maiden name: Georgianna Green
15. Birthplace: Maryland

16. Informant: Mrs. Charles Snyder
Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 8/2/47 (month) (day) (year)

Cemetery or crematory: Leister's Cemetery

Location: near Westminster, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. (Date rec'd by registrar) 19 47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 19 47, at 8¾ p M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 1st 1947, to July 31st 1947 and that I last saw h alive on July 31st 1947

Immediate cause of death	DURATION
Chronic myocarditis	5 yrs
Due to: arteriosclerosis	10 yrs
Due to:	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. T. Billingslea M.D.
M. D. or other

Address: Westminster Md. Date signed 8-1-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1246

05925

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 186 E. Green St.

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: Theodore Jeremiah Mathias

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Nannie R. Mathias

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): May 14, 1870

8. AGE: Years	Months	Days	If less than one day
77	1	26	..... hrs. ..... min.

9. Birthplace: Adams County, Penna. (Town, county, and state)

10. Usual occupation: school traffic officer

11. Industry or business

FATHER — 12. Name: Joseph Mathias

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Eliza M. Weishoar

15. Birthplace: Missouri

16. Informant: Herbert G. Mathias

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 7/13/47 (month) (day) (year)

Cemetery or crematory: Leister's Cemetery

Location: near Westminster, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 7/11/47 (Date rec'd by registrar) L. L. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10 1947, at 4 p. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1947, to July 10 1947 and that I last saw h.. alive on July 10 1947

	DURATION
Immediate cause of death: Coronary Thrombosis	3 hrs.
Due to: Myocarditis	Several yrs.
Due to:	
Other conditions: Contusion of Chest	3 mos

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: L. L. Woodward M. D.

Address: Westminster Date signed: 7/11/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05926

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 7 mo's, 13 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 19 S. Dallas Street (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: LILLIAN LEE MORTON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 5, 1936

8. AGE: Years: 10 | Months: 9 | Days: 11 | If less than one day: hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business:

FATHER
12. Name: Charles Morton
13. Birthplace: Unknown

MOTHER
14. Maiden name: Bessie Stedman
15. Birthplace: Unknown

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 20 1947 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: Baltimore 17, Md.

18. Funeral director: Geo. E. Nelson
Address: 1303 Fesstonans St

19. 7/16 19 47 (Date rec'd by registrar) Albert R. Smallhorn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 16, 1947, at 3.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 3, 1945, to July 16, 1947
and that I last saw her alive on July 16, 1947

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Nov. 1945

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md Date signed: 7/16/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

05927

Reg. Diat. No.

1. PLACE OF DEATH:
County Carroll
City or town Eldersburg Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Eldersburg Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route #1 Sykesville
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Millard Durham Palmer

3.(b) Social Security Number

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Widower
6.(b) Name of husband or wife Florence Goldie Palmer
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 12 - 1891
8. AGE: Years 56 Months 4 Days 7 If less than one day hrs. min.
9. Birthplace Mt. Washington Md.
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business Post Office
FATHER 12. Name George Henry Palmer
13. Birthplace Maryland
MOTHER 14. Maiden name Sarah Catherine Freeland
15. Birthplace Maryland
16. Informant James Henry Palmer
Address Route #1 Sykesville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 18-1947 (month) (day) (year)
Cemetery or crematory Mount Clare
Location Randallstown, Maryland
18. Funeral director Burgee Funeral Home
Address 3631 Falls Road
19. 7/16 1947 A. C. Hedrick Registrar
(Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 July 1947 at 4:15 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 July 1946 to 14 July 1947 and that I last saw h.. l.. alive on 10 July 1947

Immediate cause of death: arteriosclerotic cardio-vascular disease with hypertension and chronic myocarditis — DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D. H. Lawrence M.D.
M. D. or other
Address Sykesville, Md. Date signed 7/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93a

05928

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Union Bridge R#1
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Carroll

City or town Westminster(Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Miss Hattie B.Petry

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb.8,1888

8. AGE: Years	Months	Days	If less than one day
59	5	18	hrs. min.

9. Birthplace Carroll
(Town, county, and state)

10. Usual occupation housework

11. Industry or business

FATHER
12. Name Joseph G.Petry
13. Birthplace Md

MOTHER
14. Maiden name Catherine Starner
15. Birthplace Md

16. Informant Mrs.Wilmer E.Bish
Address Westminster,Md. Rural

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 22,1947. (month) (day) (year)

Cemetery or crematory Kriders

Location Westminster,Md.

18. Funeral director C.O.FUSS & SON

Address Taneytown,Md.

19. July 22 1947 (Date rec'd by registrar) Margaret R.Engler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1947, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 1947 to July 20 1947 and that I last saw h... alive on July 19 1947

Immediate cause of death	DURATION
Acute Myocarditis	
Due to Anemia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H.H.Legg M. D. or other

Address Union Bridge Date signed 7-20-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

05929

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 years
Hospital, Institution, or street address where death occurred: 121 Liberty St. Ext'd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. 121 Liberty Ext'd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Minnie May Phillips

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Preston Phillips
6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): Sept. 27 - 1902

8. AGE: Years	Months	Days	If less than one day
44	10	14	hrs. min.

9. Birthplace: Gaithersburg, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: James Edward Motley
13. Birthplace: Md.

MOTHER
14. Maiden name: Catherine Selby
15. Birthplace: Md.

16. Informant: Mrs. Virgie Mullican
Address: Gaithersburg, Montgomery Co. Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof July 13 - 1947 (month) (day) (year)
Cemetery or crematory: Forest Oak Cemetery
Location: Gaithersburg, Md.

18. Funeral director: H. Bankard & Son
Address: Westminster, Md.

19. 7/12 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11 1947 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945 to July 11 1947 and that I last saw h[illegible] alive on July 11 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	5½ hrs
Due to Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

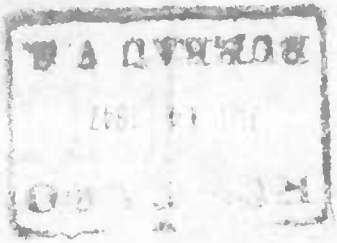
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. C. Jamuells M.D. M. D. or other
Address: Westminster Md. Date signed 7-12-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Insert correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05930

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Sykesville, Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2114 Bolton St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Bessie Anderson Roberts

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Divorced

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 23rd, 1865

8. AGE: Years	Months	Days	If less than one day
82	6	8	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: None
11. Industry or business:

FATHER
12. Name: William H. Anderson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Emily Dorsey
15. Birthplace: Maryland

16. Informant: Dorsey M. Hinks
Address: 2114 Bolton St. Baltimore, Md.

17. Burial ~~xx~~ (Burial, cremation, or removal. Which?) Date thereof: Aug. 2, 1947 (month) (day) (year)
Cemetery or crematory: Greenmount
Location: Baltimore, Md.

18. Funeral director: C. H. Weer
Address: Sykesville, Md.

19. July 31 1947 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 31 July 1947, at 6:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1947 to 31 July 1947 and that I last saw h.. alive on 31 July 1947

Immediate cause of death	DURATION
arteriosclerotic cardio-vascular disease with chronic myocarditis	
Due to senile changes	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C. H. Lawrence M.D.
M. D. or other
Address: Sykesville, Md. Date signed: 31 July 1947.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05931

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution?
Colored Branch, Henryton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1528 W. Lexington Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ALICE LOUISE ROBINSON

3.(b) Social Security Number: 220-14-7370

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 29, 1926

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
20	7	1		

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Beautician
11. Industry or business
FATHER 12. Name: William Robinson
FATHER 13. Birthplace: Virginia
MOTHER 14. Maiden name: Alice Estelle Robinson
MOTHER 15. Birthplace: Baltimore, Md
16. Informant: Mrs. Alice Robinson
Address: 1528 W. Lexington St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/2/47 (month) (day) (year)
Cemetery or crematory: Pleasant Rest Cem
Location: Towson, Md
18. Funeral director: Mrs. George A. Hollan
Address: 1631 Druid Hill Ave.
19. 7/30 19 47 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30, 19 47, at 5.25 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21, 19 47, to July 30, 19 47
and that I last saw her alive on July 30, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Parker W. Swan, M.D. M. D. or other
Address: Henryton, Md Date signed: 7/30/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

05932

Reg. Dist. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Harry G. Sell

3.(b) Social Security Number 213-18-7541 A

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Mary E. Sell

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1868

8. AGE: Years	Months	Days	If less than one day
79	2	25	hrs. min.

9. Birthplace Md
(Town, county, and state)

10. Usual occupation Elevator Operator

11. Industry or business Blue Ridge Rubber Co.,

FATHER 12. Name Emanuel Sell

13. Birthplace Pa

MOTHER 14. Maiden name Elizabeth Deutzsauer

15. Birthplace Germany

16. Informant Norris F. Sell

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 15, 1947 (month) (day) (year)

Cemetery or crematory Reformed

Location Taneytown, Md.

18. Funeral director C. O. FUSS & SON

Address Taneytown, Md.

19. July 13. 1947 (Date rec'd by registrar) Ethel M. Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1947, at 1 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12 1947, to July 12 1947

and that I last saw him alive on July 9th 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	12 days
Due to Arteria Sclerosis	2 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. M. Benner M.D.
M. D. or other

Address Taneytown Maryland Date signed July 13, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 178 (

05933

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 146 Pennsylvania Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Nellie M. Sharrer

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

B.(b) Name of husband or wife: A. Meyls Sharrer

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 6, 1882

8. AGE: Years	Months	Days	If less than one day
65	2	7	..... hrs. ..... min.

9. Birthplace: Carroll County, Maryland (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: John Reese

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary Coulson

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Guy Neudecker

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 7/16/47 (month) (day) (year)

Cemetery or crematory: St. John's Lutheran Cem.

Location: near Westminster, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 7/14 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13, 1947, at 11½ AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1940 to July 13 1947 and that I last saw h.... alive on July 13 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	2½ hrs
Due to	
Due to Uraemia (Cerebral Hemorrhage) Poisoning	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None ..... Date of .....

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: W. C. Jennette Md, M. D. or other

Address: Westminster Md Date signed: 7-14-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1860

CERTIFICATE OF DEATH

05934

Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Hampstead

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 73 West Green St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Eliza Jane Shauck

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: William N. Shauck

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 30, 1868

8. AGE: Years	Months	Days	If less than one day
79	5	20	hrs. min.

9. Birthplace: Carroll County, Maryland (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: John Wesley Barber

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Elizabeth Bowers

15. Birthplace: Germany

16. Informant: Mrs. Howard Snyder

Address: Hampstead, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 7/23/47 (month) (day) (year)

Cemetery or crematory: Mount Pleasant Cemetery

Location: Gamber, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. JUL 21 1947 19 (Date rec'd by registrar) C. Ray Dale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20 19 47 at 11½ a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 31 19 47 to July 20 19 47 and that I last saw her alive on July 18 19 47

Immediate cause of death: Cardio Vascular Renal Disease myocardial Degeneration, Valvular — DURATION

Due to: Hypertension arterio Sclerosis (General) — Several years

Due to:

Other conditions: Fractured Hip — Jan 31/47

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Acc. Date of 1/31/47

Where did injury occur? Westminster (City or town) Carroll Co. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Fall Injured at work? (a/3/47 a.s.)

23. SIGNATURE: W. Edwin Speicher M. D. or other

Address: Westminster Md. Date signed 7/22/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05935

Reg. Dist. No. 14

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mo's 11 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1530 Mc Elderry Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Virginia Lee Talley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 4, 1924

8. AGE: Years	Months	Days	If less than one day
22	11	12	hrs. min.

9. Birthplace: Petersburgs, Virginia (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: Clem Talley
13. Birthplace: Virginia

MOTHER
14. Maiden name: Jeanette Talley
15. Birthplace: Petersburgs, Virginia

16. Informant: deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 19th 47 (month) (day) (year)
Cemetery or crematory: Mt Calvary Cemetery
Location: Brookland Md
18. Funeral director: Elroy J Wilson
Address: 1000 Brantley

19. 7/16 (Date rec'd by registrar) 19 Albert E Swarthout Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 16, 1947, at 9:05 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 5 1947, to July 16 1947
and that I last saw her alive on July 16 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Nelson W Forman M.D.
M. D. or other
Address: Henryton, Md. Date signed: 7/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

05936

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:
County Carroll
City or town Manchester
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Manchester
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Henry Therit

3.(b) Social Security Number 216-03-9798

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of ~~husband~~ or wife Ada J Therit
6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) May 6 - 1886

8. AGE:

Years	Months	Days	If less than one day
61	2	4	hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name George Therit
13. Birthplace Germany

MOTHER
14. Maiden name Anna Elisabeth
15. Birthplace Germany

16. Informant Mrs Wm H Therit
Address Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 13 47 (month) (day) (year)
Cemetery or crematory Manchester
Location Carroll Co. Md

18. Funeral director Edw Stipton
Address Hampstead Md

19. July 12 1947 (Date rec'd by registrar) Wm H P Lemmon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1947, at 6 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21 1946, to July 10 1947
and that I last saw him alive on July 9 1947

Immediate cause of death	DURATION
(a) Chronic Myocarditis	7
Due to (b) Hypertensive Cardio-Vascular Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE Jacob C Buck M.D.
M. D. or other
Address Hampstead Md Date signed 7-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 059374

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yrs, 14 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 9 yrs, 14 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Garrett
City or town Kitzmiller
(If outside city or town limits, write RURAL and give nearest town)
Street No. ------
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Vauken (sometimes called Vanken)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of husband or wife Rose Vauken
6.(c) If alive, give age unkn. years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1874

8. AGE: Years	Months	Days	If less than one day
72	6	16	....hrs. ....min.

9. Birthplace Austria (Town, county, and state)
10. Usual occupation Miner; Farmer
11. Industry or business Coal mine; Own farm

FATHER
12. Name John Vauken
13. Birthplace Austria

MOTHER
14. Maiden name Rose ----
15. Birthplace Austria

16. Informant Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-9-47 (month) (day) (year)
Cemetery or crematory Blaen
Location Blaen, W. Va.
18. Funeral director C. Harry Weer
Address Sykesville, Md.
19. July 7 1947 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION (DST)

20. DATE OF DEATH July 5 1947, at 9:00P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16, 1942 1947, to July 5 1947
and that I last saw him alive on July 5 1947

Immediate cause of death	DURATION
Chronic Myocarditis	unkn.
Due to Arteriosclerosis	unkn.
Due to	
Other conditions Paranoid Condition	17 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations Gangrene of foot, due to arteriosclerosis Date of op. June 26
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Arnold H. Eichert M.D.
M.D. or other
Address Sykesville, Md. Date signed 7.6.47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 192

05938

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: CARROLL
City or town: Rural Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 wks
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural Sykesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Alfred Winiarz

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 2, 1933

8. AGE:

Years	Months	Days	If less than one day
14	4	10	hrs. min.

9. Birthplace: Poland (Town, county, and state)
10. Usual occupation: Scholar
11. Industry or business

FATHER
12. Name: Wietold Winiarz
13. Birthplace: Poland

MOTHER
14. Maiden name: Elizabetha Steginowska
15. Birthplace: Poland

16. Informant: Mr. Wietold Winiarz
Address: Sykesville, Md.

17. Buried (Burial, cremation, or removal: Which?) Date thereof July 15, 1947 (month) (day) (year)
Cemetery or crematory: Springfield Cemetery
Location: Sykesville, Md.

18. Funeral director: C. Harry Wear
Address: Sykesville, Md.

19. July 13 1947 (Date rec'd by registrar) C. Harry Wear Registrar

MEDICAL CERTIFICATION

Returned 3 P.M.

20. DATE OF DEATH: July 12 1947 at and 10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ____ 19__, to ____ 19__
and that I last saw h____ alive on ____ 19__

Immediate cause of death	DURATION
Electrocution by lightning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of July 12-47
Where did injury occur? Sykesville (City or town) Carroll (County) Md (State)
Injured at home, farm, industry, public place (where?) In wheat field
Means of injury: Struck by lightning Injured at work? No.

23. SIGNATURE: James T. Marsh Deputy Medical Examiner
M. D. or other
Address: Westminster Md Date signed July 13-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 192

05939

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 wks.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Rural Sykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George Winiarz

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 15, 1939

8. AGE:

Years	Months	Days	If less than one day
8	4	27	..... hrs. ..... min.

9. Birthplace: Poland (Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business

FATHER — 12. Name: Wetold Winiarz

13. Birthplace: Poland

MOTHER — 14. Maiden name: Elizabeth Stejnowska

15. Birthplace: Poland

16. Informant: Dr. Wetold Winiarz

Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 15 1947 (month) (day) (year)

Cemetery or crematory: Springfield Cemetery

Location: Sykesville, Md.

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. July 13 1947 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

Between 3 PM and 10 P.M

20. DATE OF DEATH: July 12 1947, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Electrocution by lightning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of July 12-47

Where did injury occur? Sykesville (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?) In wheat field

Means of injury: Struck by lightning Injured at work? No

23. SIGNATURE: James T. Wood Deputy Medical Examiner M. D. or other

Address: Westminster Md Date signed July 13-47

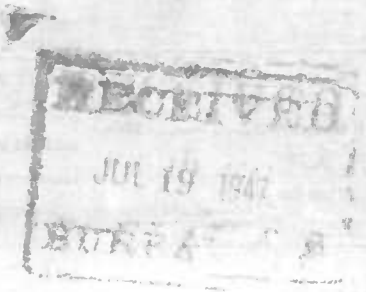
M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15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JUL 19 1941

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

45c

1:6185

Reg. Dist. No. 83

1. PLACE OF DEATH:
County: Carroll
City or town: near Winfield
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: near Winfield
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural --- Sykesville
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: CHARLES S. WOLBERT

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Hattie M. Wolbert

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Nov. 20, 1883

8. AGE: Years	Months	Days	If less than one day
63	7	25	..... hrs. ..... min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: Farmer--retired
11. Industry or business

FATHER
12. Name: George Wolbert
13. Birthplace: Maryland

MOTHER
14. Maiden name: Alberta Dorsey
15. Birthplace: Maryland

16. Informant: Mrs. Hattie M. Wolbert
Address: Sykesville, Md.

17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof 7-18-47 (month) (day) (year)
Cemetery ~~or crematory~~: Morgan Chapel
Location: Woodbine, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. 7-17 (Date rec'd by registrar) 19 47 Edna M Hewitt Registrar
Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15 1947 at 5:40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946, to July 15 1947 and that I last saw him alive on July 14, 1947

Immediate cause of death	DURATION
Uremia	1 mo
Due to Cachexia	2 mo
Due to Carcenoma of Mouth	2 yrs
Other conditions 6 hr. Myocarditis	?

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J Stanley Grabill M. D. or other
Address: Mt Airy, Md Date signed: 7/16/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05940

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Insure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 mo's 24 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium

How long in hospital or institution? Colored Branch, Henryton

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 2901 Mathews St. (If rural, give LOCATION)

2. (a) If veteran, name war:

3. (a) FULL NAME: Katie YOung

3. (b) Social Security Number: 217-22-2799

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	colored	married

6. (b) Name of husband or wife: Lawrence Young

6. (c) If alive, give age: 24 years

7. Birth date of deceased (mo., day, yr.): March 3, 1923

8. AGE: Years	Months	Days	If less than one day
24	4	14	..... hrs. ..... min.

9. Birthplace: North Caroline (Town, county, and atste)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Roger Phipps

FATHER — 13. Birthplace: N. Caroline

MOTHER — 14. Maiden name: Alice Foots

MOTHER — 15. Birthplace: N. Caroline

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 19. 1947 (month) (day) (year)

Cemetery or crematory:

Location: Sittleton N. C.

18. Funeral director: Mrs Robert Elliott daughter

Address: 1129 N. Caroline St.

19. 7/17 1947 (Date rec'd by registrar) Albert R Swinkham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17 1947 at 7:45A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 23 1946 to July 17 1947

and that I last saw her alive on July 17 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug. 28 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other

Address: Henryton, Md Date signed: 7/17/47